If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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continuation sheet 1

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Bureau of Health Care Quality & Compliance							07/21/2009 APPROVEI
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		NVN4644HIC				07/1	5/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CESSAB	ELLA RESIDENTIAL	SUITE	8295 OPA RENO, N\	L STATION / 89506	DRIVE		
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	Based on record re did not ensure the	not met as evidence view on 7/15/09, the copies of the genera of 2 residents were dent #1 and #2).	facility I physical				
H 050	Tuberculosis-Empl	oyees		H 050			
	dependent and hor care: Management cases; surveillance counseling and pre 1. A case having tu considered to have facility or a facility managed in accord the Centers for Dis as adopted by refesubsection 1 of NA 2. A medical facility or a home for individual maintain surveillant or home for tuberce	aberculosis or suspense tuberculosis in a marger for the dependent marger lance with the guidelease Control and Properties of the dependent in paragraph (a.C. 441A.200.) The properties of the dependent of the	sidential cted oyees; cted case edical ust be lines of evention (h) of ependent e shall the facility sis				

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recommendations of the Centers for Disease Control and Prevention for preventing the

subsection 1 of NAC 441A.200.

transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of

3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall

have a:

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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVN4644HIC

B. WING

07/15/2009

NAME OF PROVIDER OR SUPPLIER

stage: and

CESSABELLA RESIDENTIAL SUITE

OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

8295 OPAL STATION DRIVE

A. BUILDING

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	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	H 050	Continued From page 2	H 050		
		(a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and			

(b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination.

any other communicable disease in a contagious

If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.

- 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis.
- 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis.
- 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines

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PRINTED: 07/21/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING NVN4644HIC 07/15/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8295 OPAL STATION DRIVE **CESSABELLA RESIDENTIAL SUITE RENO, NV 89506** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) H 050 Continued From page 3 H 050 of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A,200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop, if symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 7/15/09, the facility Corrected measures attached under

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failed to ensure 1 of 3 employees complied with

testing (Employee #3 was hired on 11/21/08 and

did not have a physician's statement/physical. The employee's file contained a chest x-ray

dated 11/7/07 but there was no evidence a TB

signs and symptoms review was done on hire).

NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment;

H 055 Tuberculosis-Residents

NAC 441A.375 regarding tuberculosis (TB)

H₀₅₅

Check.

Exhibit 2 which Includes Physician

Statement, Annual TB Symptoms

Check as well as copy of Fingerprint

Form for State and Federal Background

Rureau	of Health Care Quali	ity & Compliance			\bigcirc		07/21/2009 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM NVN4644HIC			(X2) MULTI A. BUILDIN B. WING	IPLE CONSTRUCTION G	(X3) DATE SU COMPLE		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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H 055	Continued From pa	nge 4		H 055			
	before admitting a extended care, skill care, the staff of the chest radiograph of within 30 days preceded for extended care, care shall: (a) Before admitting home, determine if (1) Has had a coug (2) Has a cough where (3) Has blood in his (4) Has a fever which cold, flu or other age (5) Is experiencing (6) Is experiencing (7) Has been in clothas active tubercul (b) Within 24 hours person with a history within staff of the staff of the care, care shall: (a) Before admitting home, determine if (1) Has had a cough where (2) Has a cough where cold, flu or other age (3) Is experiencing (6) Is experiencing (7) Has been in clothas active tubercul (b) Within 24 hours person with a history within the care in th	vise provided in this person to a medical led nursing or interme facility shall ensured the person has been been admission to the person has been been admission to the person to the dependent, ential care or a mediskilled nursing or interpretation or interpretation of the person: The person is productive; as sputum; the is not associated oparent illness; night sweats; unexplained weight se contact with a person to the person in the person in the person is productive; as the person is productive; as the person in the person in the person is productive; as the person in t	facility for nediate e that a n taken the section, a home cal facility ermediate sility or eeks; with a loss; or rson who uding a te-Guerin				

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home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is

(c) If the person has only completed the first step

sooner.

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Bureau of	Health	Care	Quality	&	Compliance

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STATEMENT OF DEFICIENCIES	1 000	DOMEDER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION						
A. BUILDING						
B. WING						

(X3) DATE SURVEY COMPLETED

NVN4644HIC

07/15/2009

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

CESSABELLA RESIDENTIAL SUITE

STREET ADDRESS, CITY, STATE, ZIP CODE

8295 OPAL STATION DRIVE

CESSABELLA RESIDENTIAL SUITE		·					
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H 055	Continued From page 5		H 055				
H 055	of a two-step Mantoux tuberculin skin to the 12 months preceding admission, end the person has a second two-step Mantuberculin skin test or other single-step tuberculosis screening test. After a perhad an initial tuberculosis screening test facility or home shall ensure that the person a single tuberculosis screening test and thereafter, unless the medical director designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of tedocuments that determination. The risk exposure and corresponding frequency examination must be determined by form guidelines as adopted by reference in person with a documented history positive tuberculosis screening test is a from skin testing and routine annual characteristics of the facility shall ensure that the person is evaluated annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determined that a person has had a cough for more weeks and that he has one or more of symptoms described in paragraph (a) of subsection 2, the person may be admitsed to the staff of the facility or home described in paragraph (a) of subsection 2, the person may be admitsed to the staff of the person may be admitsed to the staff of the person may be admitsed to the person to the person may be admitsed to the person to the person may be admitsed to the person to the person may be admitsed to the person to the person may be admitsed to the person to	son has st, the erson has hually or his esting and tof rof flowing the baragraph of a exempt lest or home ed at least of termines e than 3 the other of ted to the	Н 055				
	facility or home if the staff keeps the prespiratory isolation in accordance with guidelines of the Centers for Disease C Prevention as adopted by reference in (h) of subsection 1 of NAC 441A.200 u	the Control and paragraph ntil a					
	health care provider determines wheth person has active tuberculosis. If the sable to keep the person in respiratory in the staff shall not admit the person until care provider determines that the person	taff is not solation, il a health					

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Bureau of Health Care Quality & Compliance

STATEMENT	OF	DEFIC	IENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

X2)	MULTIPLE	CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NVN4644HIC

A. BUILDING ______

07/15/2009

If continuation sheet 7 of 8

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

8295 OPAL STATION DRIVE RENO, NV 89506

CESSABELLA RESIDENTIAL SUITE

	RE	OUCEO VM, ON:		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 055	Continued From page 6 not have active tuberculosis. 5. If a test or evaluation indicates that a penhas suspected or active tuberculosis, the stathe facility or home shall not admit the person the facility or home or, if he has already bee admitted, shall not allow the person to remathe facility or home, unless the facility or hokeeps the person in respiratory isolation. The person must be kept in respiratory isolation a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A he care provider shall not certify that a person active tuberculosis is not infectious unless the three consecutive negative sputum AFIB smakes the active tuberculosis, the staff of the facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of effective treatment for, a person having active tuberculosis. The recommendations are set in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.8. The staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the staff of the facility or home shall ensure that the person is treated to the staff of the facility o	aff of on to en ain in ome ne until re ealth with the han mears been or d for se of, and tive forth ence with ontrol200.		

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING NVN4644HIÇ 07/15/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8295 OPAL STATION DRIVE **CESSABELLA RESIDENTIAL SUITE RENO, NV 89506** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) H 055 Continued From page 7 H 055 that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 7/15/09, the facility failed to ensure 2 of 2 residents complied with Corrected measures attached under NAC 441A.380 regarding tuberculosis (TB) Exhibit 3 whereby both Resident testing (Resident #1 and #2 completed a one and i step TB test on 2/6/08. Neither resident Completed Step 1 TB Test and is completed a second step TB test or received an annual test in February 2009). Scheduled for Step 2 TB Testing On August 4 at 2:30 p.m.